Iowa Department of Human Services

Mental Health System Redesign

Children's Disability Workgroup

Discussion Paper # Two: Core Services for Children

Prepared by Technical Assistance Collaborative, Inc.
September 8, 2011

I. Introduction

As the Children's Disability Workgroup turns its attention to considering the array of core services necessary for children and families to "optimally live, learn, work and recreate in their community" it is important to bear in mind a few key findings about the child and adolescent service delivery system:[1]

- "For the majority of children, Iowa does not have an organized statewide structure or system for children's mental health and disability services. There is no local central point of coordination or "front door" for children in need of mental health or disability-related services as there is in the adult mental health and disability system."
- "Parents are left to be their own case manager without the expertise and knowledge needed to navigate the mental health system. They turn to the traditional access points for intensive services for children—DHS Child Welfare, the Juvenile Court system, the involuntary commitment process, acute mental health care settings and PMIC's even though community-based options, when available, can help avert these more costly and restrictive interventions, and keep the child in their home, school and community."
- The rate of involuntary mental health commitment filings for juveniles has doubled in the past six years.

Regardless of the core service mix, any positive impact will be significantly diminished if issues such as philosophy of care, access, workforce competencies, and cross-system outcomes are not fully addressed in the redesign. After a brief review of trends in core services, this paper will touch on each of these points.

II. Trends in Core Services for Children

The Children's Workgroup has had considerable discussion about the application of a "systems of care" strategy for multi-system/multi-service youth. Here are some other trends in service delivery:

[1] Iowa Department of Human Services: *Implementation Status Report regarding the Mental Health Services System for Children, Youth and their Families*, January 31. 2011

Services that are delivered in the child/family's natural environment: There is broad recognition that children are not readily treated in isolation from the "systems" in which they live. "Children must be seen in the context of their social environments—that is, family and peer group, as well as that of their larger physical and cultural surroundings. Childhood mental health is expressed in this context, as children proceed along the arc of development."[2] Home and school-based interventions and community-based mentoring facilitate the planning and implementation of interventions that are in vivo and idiosyncratic to the child and family. Rather than going to an office to talk about how to socialize effectively, community-based work allows for real-time and hands-on coaching. Rather than receiving habilitation services in a facility, a child can receive them in the community where they can readily be reduced and modified as skills are mastered and families can benefit from practical learning, coaching and support.

Services that are family-driven: As defined by the National Federation of Families for Children's Mental Health[3] "Family-driven" means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- Choosing culturally and linguistically competent supports, services, and providers;
- Setting goals;
- Designing, implementing and evaluating programs;
- Monitoring outcomes; and
- Partnering in funding decisions.

Competencies for providers include an understanding of the "lived experience" of children with disabilities and their parents or caretakers; and the value and use of Shared-Decision Making. Families are looking for professional expertise and guidance, but not at the cost of giving up all decision-making.

Services/supports for parents: The journey of the parent or caretaker of children with disabilities is different from that of the child. It is often exhausting and isolating. Parent Partners or Family Partners[4] who have themselves parented children with disabilities, are active

[2] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[3] www.ffcmh.org

[4] The title varies from state to state

in many states providing informal supports or direct service delivery.[5] Members of the Parent Partner Assessment Workgroup (PPAW) identified core tasks for Parent Partners:[6]

- Provides information, support and advocacy
- Helps the family navigate through the system(s)
- Helps family member understand all possible options and make informed decisions
- Promotes productive partnerships between parents and professionals

Services delivered in partnership with other systems: As identified by the Children's Workgroup, professionals in other systems—child welfare, juvenile justice, education, primary healthcare—are often in position (whether by design or default) of having to make service decisions for children. Consultation, collaboration and/or affiliation between those systems and experts in mental health and intellectual disabilities increase the likelihood that a full array of services are considered and creates opportunities for diversion from out of home placement, retention in school, avoiding new charges, etc.

The inclusion of a broad continuum of crisis services, supports and competencies: Upstream strategies that reduce the likelihood of serious and life-threatening crises and subsequent out of home placement include services delivered not just by traditional crisis providers, but all MH and ID providers with attention to:

- Effective crisis prevention, planning and practicing
- Providing early intervention at first sign of difficulty
- Providing crisis intervention that is resolution-oriented
- Availability of brief, focused crisis stabilization
- Enhanced, flexible supports and planning following crisis intervention or brief-out-of home treatment.

III. Essential elements in system redesign

As mentioned at the beginning of this paper other elements in system design are essential in assuring that the service continuum is achieving the vision.

A Shared vision and philosophy of care in working with children and families: Within communities and across systems what is the consistent vision and philosophy that guides policy development and decision-making and fulfills the promise of a life in the community for everyone?

---

[5] The use of a Parent Partner is a standard component of Wraparound Care Planning. In Massachusetts, Mobile Crisis Intervention for children is delivered by a team made up of a clinician and a Family Partner.

[6] Family Peer-to-Peer Support Programs in Children's Mental Health: A Critical Issues Guide. National Federation of Families for Children's Mental Health, 2008

Access: Children's Workgroup members envision a system with "no wrong door." The system and its framework must be logical, recognizable and accessible across the state. Access to a full array of choices is particularly important at places and times when critical decisions are being made about very restrictive services such as an involuntary inpatient commitment or placement in residential treatment.

Workforce Competency Development: The adoption of best practices requires a commitment to workforce training, program development and on-site technical assistance over a period of a several years rather than days or months. It is one thing to talk about and feel committed to recovery-oriented services or the inclusion of family voice and choice in decision-making and another thing entirely to master the skills. It requires, for many traditional professionals and treatment agencies a significant and transforming shift in policy, governance, service delivery model, job descriptions and intervention techniques.

Cross-system outcomes: It is essential that to assure the whole health of children in our communities that attention is paid to outcomes across systems rather than outcomes that are program or system-specific and that do not tell the whole story. These outcomes include performance in school, reducing penetration into juvenile justice and child welfare systems, reduced use of substances, access to and coordination with primary care, reducing out-of-home placements, and increasing access to transitional services for teenagers and young adults. It is from this macro, multi-system, public health view that gaps are most transparent and solutions are best identified.

Summary

As the Children's Workgroup identifies recommended core services it will be essential that embedded within each service description are the philosophies, competencies and outcomes necessary to achieve Iowa's vision for children and families.